

MRN: _____

DOB: _____

STANDARD Riabni™ (rituximab-arrx) PLAN OF TREATMENT for GPA or MPA

NOTE: Patient ***may be ineligible*** to receive rituximab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, newly diagnosed cardiac arrhythmias, severe abdominal pain or vomiting, and/or surgery.

1. Patient Name: _____ Height (inches): _____ Weight (lbs): _____

2. Allergies: _____

3. Diagnosis:

M31.30 Granulomatosis with Polyangiitis (GPA/Wegener's Granulomatosis) M31.7 Microscopic Polyangiitis (MPA)

Other ICD-10 Code: _____ Diagnosis description: _____

4. Pre-medications: Administered 30 minutes prior to infusion ***as selected:***

**** Premedication of Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion***

Acetaminophen: <input type="checkbox"/> 650 mg PO <input type="checkbox"/> 500 mg PO <input type="checkbox"/> 325 mg PO <input type="checkbox"/> 1000 mg PO	Diphenhydramine: <input type="checkbox"/> 25 mg IVP, <input type="checkbox"/> 50 mg IVP, <input type="checkbox"/> 25 mg PO, <input type="checkbox"/> 50mg PO or Alternate oral antihistamine to diphenhydramine: <input type="checkbox"/> Cetirizine 10 mg <input type="checkbox"/> Loratadine 10 mg <input type="checkbox"/> Fexofenadine <input type="checkbox"/> 60mgs or <input type="checkbox"/> 180mgs Methylprednisolone: <input type="checkbox"/> 125 mg IVP <input type="checkbox"/> 40 mg IVP or other _____ mg IVP Famotidine: <input type="checkbox"/> 20mg PO, <input type="checkbox"/> 40mg PO, <input type="checkbox"/> 20mg IVP, <input type="checkbox"/> 40mg IVP
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Pre-medicate with other: _____

5. DOSE:

Riabni(rituximab-arrx) **375mg/m²** per 250-500ml Sodium Chloride 0.9% IV to infuse per protocol **OR**

Other Dose: _____

6. FREQUENCY:

Orders to be completed once weekly x 4 weeks

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

7. Physician's Signature: _____ / _____ Date: _____

No Stamp Signatures

(Dispense as written)

(Substitution permitted)

Printed Physician's Name with Credentials: _____ NPI: _____

8. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

MRN: _____

DOB: _____

Guidelines for Prescribing Riabni (rituximab-aarx) for GPA or MPA

(Required documentation with all initial referrals)

Patient Name: _____

Referral Date: _____

Include signed and completed **Plan of Treatment**. (MD must complete sections 1-8)
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

Include patient demographic information and insurance information. (Copy of insurance cards if available)

Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.

* Rituximab-aarx, in combination with glucocorticoids, is indicated for the treatment of adult patients with Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA).

If patient is switching biological therapies, then MD must specify wash-out period prior to starting Rituxan® as specified of _____ weeks. Last known biological therapy: _____ and last date received: _____. (Include copy of last Rituxan® infusion record if available and currently on therapy)

Other as requested: _____

Required Pre-Screening:

Hepatitis B screening test completed. Results: (positive or negative): _____

***If Hep B results are positive, please send documentation of treatment or medical clearance.**

***Riabni™ is contraindicated in patient with active HBV. Patients who are negative for surface antigen HBsAg (-) and positive for HB core antibody HBcAB (+) or positive for surface antigen HBsAg (+), should consult liver disease experts before starting and during treatment.**

***Other:** Glucocorticoids administered as methylprednisolone 1000 mg intravenously daily for 1 to 3 days followed by oral prednisone 1 mg/kg/day (not to exceed 80 mg/day and tapered per clinical need) are recommended to treat severe vasculitis symptoms. This regimen should begin within 14 days prior to or with the initiation of rituximab and may continue during and after the 4-week course of rituximab treatment. Methylprednisolone Plan of Treatment are available at www.palmettoinfusion.com if needed.

**** Warnings/Precautions:** • **Hepatitis B Virus Reactivation**- Screen all patients for HBV infection by measuring HBsAg and anti-HBc (antibodies) before initiating treatment with Riabni™. For patients who show evidence of prior hepatitis B infection (HBsAg positive or HBsAg negative but anti-HBc positive), consult with physicians with expertise in managing hepatitis B regarding monitoring and consideration for HBV antiviral therapy before and/or during Rituxan® treatment. HBV reactivation has been reported up to 24 months following completion of Rituxan® • **Glucocorticoids administered methylprednisolone IV premed or its equivalent 30 minutes prior to each infusion are recommended to reduce the incidence and severity of infusion reactions.** Evaluation of immunizations should be completed prior to and live vaccines should not be given before or concurrently. **Serious Infections:** including fatal, bacterial, fungal, and new or reactivated viral infections can occur during and following the completion of Rituxan®. See full prescribing information.

AccuRx Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.



Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.